CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR A LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT IN DELAWARE
INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. All auxiliary forms you need are included in this packet.

If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Physician Assistant *Plus* Prescriptive Authority and Controlled Substance Application

- This application includes a section to concurrently apply for Prescriptive Authority and Controlled Substance registration(s) in addition to a Physician Assistant license. Prescriptive Authority enables you to prescribe medication under the supervision of a licensed physician in Delaware.
- If you do not wish to apply concurrently for Prescriptive Authority, you may apply later. If you decide to apply later on…
  - For Prescriptive Authority, use the *Physician Assistant Application for Prescriptive Authority*.
  - For a Controlled Substance registration, use the *Controlled Substance Application for Physician's Assistant*.
- You need a Controlled Substance registration for ***each*** business/practice where you will prescribe controlled substances. For example, if you work for two different employers, a hospital and a primary care physician, and you will prescribe controlled substances at each, you need two registrations—one for the hospital and one for the primary care practice.
- The registration associated with each business/practice covers all Delaware locations of that business/practice where you may prescribe controlled substances. The address associated with each business/practice is typically its main location. For example, if you work for one primary care practice with locations in two Delaware towns, you need only one registration and you may prescribe controlled substances at both locations.
- When your application is complete, allow 4-8 weeks to receive your permanent Physician Assistant license. *After* your permanent Physician Assistant license is issued and prescriptive authority is approved, any controlled substance registration(s) for which you applied will be processed. Allow an additional 3-4 weeks to receive your Controlled Substance registration(s).
- When your Delaware Controlled Substance registration(s) is approved, you must then file for a federal DEA registration. ***Before*** **prescribing controlled substances in Delaware, you must have *both* your federal DEA registration and Delaware Controlled Substance registration(s).**

Checklist for *All* Applications

The following requirements apply to all applications regardless of whether you are applying by Examination, Reciprocity/Endorsement or Reapplication.

☐ Submit completed, signed and notarized application form.
- Make sure all questions are answered unless the instructions tell you to skip a question.
- Read the AFFIDAVIT section.
- Sign the application in front of a notary public.
- Forms that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose processing fee by check or money order made payable to "State of Delaware."
- Applications submitted without this processing fee will be rejected.
- The amount of the fee depends on what you are applying for. You may combine the fees in one payment.

IF you are applying for…	**THEN…**
Physician Assistant license ***only***	Submit $139.
Physician Assistant license and one or more Controlled Substance registrations ***concurrently***	Add $65 for ***each*** Controlled Substance registration to the PA fee.
Physician Assistant license and Temporary PA license	Add $32 to the PA fee. Caution: Submit this fee *only if* you meet the requirements for a Temporary license. See **Temporary Licensure** below.

☐ If you now hold, or have *ever* held, a PA license in any jurisdiction other than Delaware, arrange for the Board office to receive a *Verification of Physician Assistant License* form from *each* jurisdiction where you have held a license.
- Before forwarding the form, check whether the jurisdiction requires a fee.
- The Board office must receive the completed verification *directly* from the other jurisdiction. The jurisdiction's seal must be affixed to the form.
- Internet verifications or faxed verifications will not be accepted.

☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

☐ Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Banks (NPDB/HIPDB) website at www.npdb-hipdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, mail (do not fax) the ***original report*** to the Board office.

☐ If you answer "yes" to any questions in the DISCLOSURES section, you must submit a separate signed statement to fully explain your answer.

Additional Requirements for Applications by Examination

The following requirements apply when you are filing your initial application for PA licensure on the basis of the Physician Assistant National Certifying Examination (PANCE).

☐ Submit an 8" X 11 1/2" copy of your Physician Assistant diploma.

☐ Arrange for the Board office to receive a *Verification of Physician's Assistant Education* form from the PA program from which you graduated.
- The program from which you graduated must be AMA-approved.
- The Board office must receive the completed form *directly* from the school. The school's seal must be affixed to the form. If no seal is available, the form must be notarized.
- Internet verifications or faxed verifications will not be accepted.

☐ Submit an 8" X 11 1/2" copy of your National Commission on Certification of Physician Assistants (NCCPA) Certificate.
- If you are applying by Examination but are not yet nationally certified, you do not need to submit this copy.

☐ Arrange for the Board office to receive an official *Verification of Certification* from NCCPA, sent directly to the Board office.

Additional Requirement for Applications by Endorsement/Reciprocity and Reapplications

The following requirement pertains only when

- you are applying on the basis of endorsement/reciprocity (current PA licensure in another state or jurisdiction) or reapplying for Delaware PA licensure that lapsed
- your CME within the past two years is current.

☐ Submit proof of 100 hours of continuing medical education (CME).
  - The CME must consist of 40 hours of AMA Category I CME (Section 25.2 of the Board's Rules and Regulations).

Temporary Licensure

You may be granted a temporary license if you

- have graduated from an accredited PA program and otherwise meet all the requirements for licensure except for passing the PANCE, and
- have registered to take the next available PANCE.

The temporary license remains valid until the examination results are available. If you fail the PANCE, the temporary license immediately becomes null and void and you must cease practicing as a PA.

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APPLICATION FOR A LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT IN DELAWARE

TYPE OF APPLICATION

1. Select the type of application you are filing (check one):

   ☐ Examination – I have *never* been licensed in *any* state or U.S. territory and am applying on the basis of the Physician Assistant National Certifying Examination.

   ☐ Endorsement/Reciprocity – I hold a *current, active* PA license in another state or U.S. territory.

   ☐ Reapplication – I previously held a Delaware PA license that is lapsed. My license number was: _____

2. Are you also applying for a temporary license because you have not yet taken and passed the examination? Yes ☐ No ☐

3. Are you also applying for Prescriptive Authority? Yes ☐ No ☐ If yes, check one:

   ☐ Non-Controlled Substances *Only*

   ☐ *Both* Controlled *and* Non-Controlled Substances

4. Are you *concurrently* applying for one or more Delaware Controlled Substance registrations? Yes ☐ No ☐

IDENTIFYING AND CONTACT INFORMATION

5. Full Name: _____ _____ _____
   Last First Middle

6. Other Names Used: _____ _____ _____

7. Mailing Address: _____

   _____ _____ _____
   City State Zip

8. Phone: _____ _____ Email: _____
   Home Work

9. Date of Birth (month/day/year): _____

10. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
    - If yes, enter your SSN: _____
    - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

EDUCATION, EXAMINATIONS AND CERTIFICATION – *All* applicants complete this section.

11. Are you a graduate of an AMA-approved PA program? Yes ☐ No ☐ If yes, enter this information about your program:

    Institution Name: _____ Graduation Date: _____

    Address: _____ _____ _____ _____
    Street City State Zip

    Submit an 8" X 11 1/2" copy of your Physician Assistant diploma and arrange for the Board office to receive a *Verification of Physician's Assistant Education* form from the PA program, sent *directly* from the school(s).

12. Have you ever been deemed ineligible to sit for a PA national certifying examination for any reason?
    Yes ☐ No ☐ If yes, explain: _____
    _____

13. Are you certified as a PA by the National Commission on Certification of Physician Assistants (NCCPA)?
    Yes ☐ No ☐ If yes, enter the following information about your certification and *skip to the **CME** section*:
    Certification Number: _____ Date of Certification: _____

14. Have you taken the national certifying examination? Yes ☐ No ☐
    - If yes, enter the date you sat for the exam: _____
    - If no, enter the date of the exam for which you have registered: _____

CONTINUING MEDICAL EDUCATION – Complete this section *only if* you are applying by Endorsement/Reciprocity or by Reapplication.

15. Do you currently log continuing medical education (CME) with a nationally recognized agency? Yes ☐ No ☐ If yes, check agency:
    ☐ NCCPA
    ☐ AAPA
    ☐ Other – Enter agency: _____

16. Within the past two years, have you completed at least 100 hours of CME, 40 of which are Category I CME? Yes ☐ No ☐ **If yes, submit proof of your current CME.**

LICENSURE HISTORY – *All* applicants complete this section.

17. Have you ever been denied a license or a registration to practice as a PA? Yes ☐ No ☐ If yes, explain:
    _____
    _____

18. Have you ever held a PA license in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, list *each* jurisdiction where you now hold, or have *ever* held, a PA license.

JURISDICTION	LICENSE NUMBER	EXPIRATION DATE

Arrange for the Board office to receive a *Verification of Physician Assistant License* form from *each* jurisdiction where you have held a license.

DISCLOSURES – *All* applicants complete this section.

If you answer "yes" to any question in this section, submit a signed statement fully explaining your answer. The statement should specify where and when the incident occurred, the issues involved and any further information you wish to provide.

19. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐

    Arrange for the Board office to receive state and federal criminal background checks.

20. Have you ever been denied a controlled substance registration? Yes ☐ No ☐

21. Have you ever been the subject of any disciplinary action (formal or informal) by any federal or state agency or any hospital credentials committee including, but not limited to, revocation or suspension of a controlled substance registration or is any such action pending? Yes ☐ No ☐

    Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) and, when you receive the report, mail the *original* to the Board office.

22. Within the past two years, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as a physician assistant, including use or abuse of dangerous or addicting substances? Yes ☐ No ☐

23. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ☐ No ☐

24. Within the past two years, have you engaged in the illegal use of controlled dangerous substances? Yes ☐ No ☐

25. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes ☐ No ☐

PRESCRIPTIVE AUTHORITY AND CONTROLLED SUBSTANCE REGISTRATION – Complete this section *only if* you answered "Yes" to Question 3 (applying for prescriptive authority).

26. Complete the following information about ***each*** individual business/practice where you will be practicing in Delaware. If you will be prescribing controlled substances at any of these businesses/practices, you must have a ***separate*** Controlled Substance registration for ***each*** individual business/practice where you will prescribe controlled substances in Delaware. However, the registration for a business/practice covers all Delaware locations of that business/practice.

Enclose a Controlled Substance registration fee for *each individual* business/practice where you will be prescribing controlled substances.

FIRST PRACTICE

Business/Practice Name: _____

Location Address: _____
(If more than one location, enter main location. *No PO Box!)*

_____ DE _____
City State Zip

Business Phone: _____ Email: _____

Will you be prescribing controlled substances at any location of this business/practice? Yes ☐ No ☐

PRACTICE 2

Business/Practice Name: _____

Location Address: _____
(If more than one location, enter main location. *No PO Box!)*

_____ DE _____
City State Zip

Business Phone: _____ Email: _____

Will you be prescribing controlled substances at any location of this business/practice? Yes ☐ No ☐

PRACTICE 3

Business/Practice Name: _____

Location Address: _____
(If more than one location, enter main location. *No PO Box!)*

_____ DE _____
City State Zip

Business Phone: _____ Email: _____

Will you be prescribing controlled substances at any location of this business/practice? Yes ☐ No ☐

If you need more room to list additional Delaware business/practice(s), provide the same information on a separate sheet and enclose it with the application.

27. Do you have a federal DEA number? Yes ☐ No ☐ If yes, enter number: _____

If you are applying for a Delaware Controlled Substance registration(s) and do not have a federal DEA number, you must file for the federal DEA registration after your Delaware registration is approved. *Before* prescribing controlled substances in Delaware, you must have *both* your federal DEA registration and Delaware Controlled Substance registration(s).

28. Enter the names of ***all*** physicians who will supervise you, regardless of business/practice or location:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Arrange for *each* supervising physician you listed above to submit a *Statement of Supervising Physician* (see next page). Enclose all statements with the application.

29. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Practice of any change in supervising physician(s) or schedule(s) authorized. Yes ☐ No ☐

You may copy this page.

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____
2. Delaware Physician License Number: **C**___**-**_____ 3. Specialty: _____
4. DEA Numbers :_____ _____
   Federal Delaware
5. Which controlled substance schedules are you authorized to prescribe? ☐ II ☐ III ☐ IV ☐ V
6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe *under your supervision*?** ☐ II ☐ III ☐ IV ☐ V
7. Are you delegating authority to the Physician Assistant applicant to request and issue professional samples of controlled legend medications? Yes ☐ No ☐ **If yes, as the supervising physician, you remain ultimately responsible for prescribing, dispensing and storing the controlled substances even though you are delegating authority to the PA.**
8. **As the supervising physician, I understand that I may not at any given time supervise more than two physician assistants, unless a regulation of the Board increases or decreases the number (24 *Del C.* §1771(e)).** Yes ☐ No ☐
9. How many Physician Assistants do you currently supervise? _____
10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Practice of any change in supervising physician(s) or schedule(s) authorized. Yes ☐ No ☐

Signature of Supervising Physician: _____ Date: _____

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____
2. Delaware Physician License Number: **C**___**-**_____ 3. Specialty: _____
4. DEA Numbers :_____ _____
   Federal Delaware
5. Which controlled substance schedules are you authorized to prescribe? ☐ II ☐ III ☐ IV ☐ V
6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe *under your supervision*?** ☐ II ☐ III ☐ IV ☐ V
7. Are you delegating authority to the Physician Assistant applicant to request and issue professional samples of controlled legend medications? Yes ☐ No ☐ **If yes, as the supervising physician, you remain ultimately responsible for prescribing, dispensing and storing the controlled substances even though you are delegating authority to the PA.**
8. **As the supervising physician, I understand that I may not at any given time supervise more than two physician assistants, unless a regulation of the Board increases or decreases the number (24 *Del C.* §1771(e)).** Yes ☐ No ☐
9. How many Physician Assistants do you currently supervise? _____
10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Practice of any change in supervising physician(s) or schedule(s) authorized. Yes ☐ No ☐

Signature of Supervising Physician: _____ Date: _____

TEMPORARY LICENSE – Complete this section *only if* you answered "Yes" to Question 5.

Delaware law at 24 *Del. C*. §1774 (a) provides:

"Notwithstanding any provision of this subchapter to the contrary, the Executive Director, with the approval of a physician member of the Board, may grant a temporary license to an individual who has graduated from a physician or surgeon assistant program which has been accredited by the Committee on Allied Health Education and Accreditation (CAHEA) of the American Medical Association (AMA) or a successor agency and who otherwise meets the qualifications for licensure but who has not yet taken a national certifying examination, provided that the individual is registered to take and takes the next scheduled national certifying examination. A temporary license granted pursuant to this subsection is valid until the results of the examination are available from the certifying agency. If the individual fails to pass the national certifying examination, the temporary license granted pursuant to this subsection must be immediately rescinded until the individual successfully qualifies for licensure pursuant to this subchapter."

30. I certify that I have read 24 *Del. C*. §1774 (a), cited above, and that I agree to comply with the terms and conditions of temporary licensure. Yes ☐ No ☐

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded.

Please note: When your application is <u>complete</u>, please allow 4-8 weeks to receive your permanent Physician Assistant license. After your permanent Physician Assistant license is issued and prescriptive authority is approved, any controlled substance registration(s) for which you applied will be processed. Allow an additional 3-4 weeks to receive your Controlled Substance registration(s).

AFFIDAVIT

I declare and affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

I consent to the release of any information by any person having such information, to the Delaware Board of Medical Practice regarding my education, background or qualifications to be licensed as a Physician Assistant, and understand that such information shall be used by the Board of Medical Practice in consideration of my application to practice in Delaware. I hereby release and hold harmless from liability any persons who in good faith provide such information to the Delaware Board of Medical Practice.

Signature of Applicant: _____ Date: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____2_____.

Signature of Notary: _____

SEAL

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Criminal background checks, both federal and state, are required for all applicants for Medical licensure. **You must complete this requirement *even if* you recently had a criminal background check done for some other reason.**

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 672-5319

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00 to cover both the State and Federal criminal checks. As fees are subject to change, contact the agency where you plan to submit your forms for current fees. Cash, money orders and credit cards other than American Express are accepted. *Personal checks are not accepted.*

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 672-5319** to request a fingerprint card.

2. Send your *Authorization for Release of Information* form, fingerprint card, and $69.00 fee (by personal check or money order) to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨ ***Allow four weeks for receipt of results.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OF MEDICAL PRACTICE OFFICE!!

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AUTHORIZATION FOR RELEASE OF INFORMATION
CRIMINAL HISTORY RECORD CHECK

REASON FOR REQUEST: **Delaware Board of Medical Practice - License Application**

_____ _____ _____ _____
LAST NAME FIRST NAME MI SUFFIX

ALL OTHER NAMES USED IN THE PAST:

1. _____
2. _____
3. _____
4. _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO THE ADDRESS I HAVE DESIGNATED BELOW:

Name/Company: **Delaware Board of Medical Practice**

Address: **861 Silver Lake Boulevard, Suite 203**

City/State: **Dover, DE 19904**

AUTHORIZATION TO RELEASE INFORMATION:

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **DATE:** _____

Phone Number Home: _____ Work: _____

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

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VERIFICATION OF PHYSICIAN ASSISTANT LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a Physician Assistant.

Licensing Authority:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ DOB:_____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Medical Practice. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/U.S. Territory of _____ License Number: _____ Issue Date (mm/dd/yyyy): _____ Expiration Date (mm/dd/yyyy): _____ Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ **If yes, please enclose a certified copy of the Board Order with this license verification.**
CERTIFICATION **AFFIX** **OFFICIAL** **SEAL HERE**	**Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.** **Printed Name of Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.**

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VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Physician Assistant applicants should send this form to the program from which graduated.

Educational Institution:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ Birth Date:_____ Other Name(s) Used: _____ I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my degree or certification is required. I am authorizing the release of the information requested on this form. **Applicant Signature:** _____ Date: _____
This section to be completed by Institution.	1. Enter the dates the applicant named above was enrolled in your institution: From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ 2. Was the applicant awarded a degree? Yes ☐ No ☐ • If yes, enter: Degree Received: _____ Date (mm/dd/yyyy) Degree Conferred: _____ • If no, attach explanation of reason applicant did not receive a degree.
AFFIX INSTITUTION OR NOTARY SEAL HERE	**I certify that the information above is an accurate account of the applicant's records and is true and correct.** **Printed Name of Institution Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.**